Melissa Mullane Padgett, DDS

General Dentist Accepting Children

We are pleased to welcome you and your child to our practice! Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

Patient Information

Patient Name _____ Preferred Name _____

DOB_____Gender_____ Preferred Phone _____Text? ☐ Y ☐ N

Address _____

Who referred you? _____

Guardian Information

Parent/Guardian's Name _____

Social Security # _____ DOB _____

Address (if different than above) _____

_____

Phone (Home) _____ (Cell)_____

(Work) _____

Email Address _____

Parent/Guardian's Name_____

Social Security # _____ DOB _____

Address (if different than above) _____

_____

Phone (Home) _____ (Cell)_____

(Work) _____

Email Address _____

Dental Insurance Information

Primary: Plan name _____

Subscriber's name _____ Employer _____

Secondary: Plan name _____

Subscriber's name _____ Employer _____

Does the child have dental coverage through the State of Ohio? Medicaid ☐ Yes ☐ No

Caresource ☐ Yes ☐ No United Health Care Community Plan ☐ Yes ☐ No BCMH ☐ Yes ☐ No

If yes, we must have a copy of the card at **EACH VISIT**.

Primary or Secondary coverage (circle one) ID # _____

Signature_____ Date_____ Relationship to patient _____

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Medical History

Child's Name _____ DOB _____

Pediatrician/Medical Physician Name/Phone_____

Specialist (cardiologist, endocrinologist, counselor, etc,) Name/Phone _____

Do you have or have you had any of the following? (Check all that apply)

- ☐ ADD/ADHD
- ☐ Anxiety General
- ☐ Anxiety Dental
- ☐ Asthma
- ☐ Autism/Asperger's
- ☐ Bipolar
- ☐ Bleeding Disorder
- ☐ Cancer/Leukemia
- ☐ Cerebral Palsy
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Down Syndrome
- ☐ Epilepsy/Seizures
- ☐ Frequent Ear Infections
- ☐ Frequent Fainting
- ☐ Hearing Difficulties/Deaf
- ☐ Heart Problems
- ☐ Atrial Septal Defect
- ☐ Ventral Septal Defect
- ☐ Mitral Valve Prolapse
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ HIV/AIDS
- ☐ Kidney Problems
- ☐ Learning Disabilities
- ☐ Liver Problems
- ☐ Mental Health Problems
- ☐ Non-verbal (ages 3+)
- ☐ Rheumatoid Arthritis
- ☐ Tonsillitis
- ☐ Other _____

Surgery? Describe_____

Admitted to hospital or over night stay? Describe_____

Medications, vitamins, supplements? Name/s _____

For what ?_____

Allergies: (Check all that apply)

- ☐ Amoxicillin/Penicillin
- ☐ Codeine
- ☐ Latex
- ☐ Food _____
- ☐ Seasonal _____
- ☐ Other Medications _____

Dental History

Bad experience? Y/N Explain_____

Brush teeth _____ times per day/week

Floss teeth _____times per day/week

Injuries to mouth, teeth, head_____

Children under age 5:

Pacifier Y/N Age stopped_____

Bottle Y/N Age stopped_____

Sippy cup Y/N Age stopped_____

Thumb sucking Y/N Age stopped_____

Sleeping with bottle/sippy cup Y/N Age stopped_____

Other info?_____

Authorization

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform Dr. Padgett or her dental team if my minor child ever has a change in health.

Minor/Child Consent

I am the parent, guardian or personal representative of _____(name of minor child) and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental team to perform necessary services for the child named above, including but not limited to radiographs, administration of anesthetics, and administration of nitrous oxide, which are deemed advisable by Dr. Padgett, whether or not I am present when the treatment is rendered.

Signature_____ Date_____ Relationship to patient _____

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INSURANCE AND FINANCIAL POLICY

Dr. Melissa Padgett and her team believe that your child deserves the best dental care possible, and we will always try to present you with the best solutions possible to treat each individual situation. We provide outstanding dental care to hundreds of patients. Some of our patients have dental insurance benefits, but others do not. Whether you are fortunate enough to have these benefits or not, here are some important things we would like you to know.

Initial

_____ * Your dental benefits are based upon a contract made between your employer and an insurance company, not with this office. **If you have any questions regarding your dental benefits, please contact your employer or insurance company directly.**

_____* We currently accept all private insurance plans. This does **NOT** mean that we are a participating provider for your plan. Due to the extensive number of available plans and the constant changes within these plans, it is impossible to know for sure what your plan will pay. We can estimate your portion based on the most current information we have, but this is **ONLY AN ESTIMATE**. If you would like to know your insurance benefit, we will be happy to file a pre-treatment determination with your company prior to treatment. This can delay treatment, but will give an exact out-of-pocket figure that you will be responsible for.

_____* We will bill your insurance as a courtesy. If your insurance company does not pay within 90 days, we reserve the right to request payment in full for services provided to you. You will become responsible for collecting insurance funds that are due to you. This situation is rare, but you must understand that your insurance plan is a legal contract between you and the insurance company. Ultimately, you are responsible for all charges you incur for services provided by our office.

_____* You are responsible for bringing your insurance card (if applicable) to each visit, as well as keeping our office aware of any changes in insurances, subscriber information, etc. If you have not updated your insurance information with us, please do not become upset if you receive a statement from us for charges incurred.

_____* If any portion of your account balance becomes greater than 90 days past due, we will refer your account to our collections service and a processing fee will be charged to the account.

_____*Payment in full is required on the day of treatment. We will no longer permit monthly payments other than a pre-arranged credit card on file or on *CareCredit*. Placing a credit card on file or signing up for *CareCredit* is fast, easy and only takes a few minutes of time with one of our trained team members.

I agree to the above conditions.

Print Patient(s) Name: _____ Date _____

Parent Signature: _____

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MISSED or BROKEN APPOINTMENTS

Thank you for choosing our practice. Your child's dental health is our highest priority. As such, we believe it would be a disservice to you if we did not emphasize one of your responsibilities with regard to the treatment of your child. Most parents are fully aware of their responsibilities and partner with us to ensure their children's health. To those of you who fit this category, we thank you and understand that the policy outlined below will not be relevant to you.

*Your appointment time is set aside for your child, and it is **your responsibility** to get your child to our practice **on time**.* At least 48 hours prior to your appointment, we make the effort to call you reminding you of your appointment. This is a courtesy call made with enough advance notice so that if you have a conflict, you may change your appointment. That being said, it is your responsibility to notify us of any conflict and reschedule if necessary.

Please understand that on any given day, our available appointment times may be fully booked several weeks in advance. Prime appointment times (after school or when school is on break) are booked months in advance. Thus, if you miss your appointment, you prevent us from using that time to address another child's dental health. However, if you notify us at least 24 hours in advance, we can schedule another child who may have an immediate dental need. To reiterate, if you miss your appointment or do not give us timely notification, you prevent us from using valuable time to treat patients who are in need. Therefore, if you miss an appointment, we will follow the policy outlined below...

We define a missed appointment as your failure to show up ON TIME for a scheduled appointment or your failure to cancel at least 24 hours prior to the time of your appointment.

A.) **We realize that life sometimes gets in the way. Therefore, if you are an established patient and have a single missed appointment, our staff will call to ensure that you and your child are fine, and we will be happy to reschedule you.**

B.) **After a 2nd non-consecutive miss, we will again call to ensure that you and your child are fine. You will be reminded of this policy and we will point out that any future missed appointments will result in dismissal from the practice.**

C.) **If in the unlikely event that you miss a 3rd appointment, we will not call you to reschedule. Instead, you will be dismissed from our practice.**

D.) **If you miss 2 appointments in a row, you will also be dismissed from our practice.**

E.) **If you are a new patient and miss your initial appointment without calling, you will not be rescheduled.**

F.) **If you are late, even if only by a few minutes, there is a good chance that you will have to be rescheduled.**

We understand that most parents are responsible and work with us to address their children's dental health. Therefore, we apologize for having to implement this blanket policy in order to address a few irresponsible families. Thank you!

PARENT/GUARDIAN SIGNATURE: _____

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PRACTICE RULES AND GUIDELINES (for parents)

Dear Parents:

We first want to thank you for choosing us as your dental provider. We hope that you and your child have a great visit. We want to work together with you so that your child can have a lifetime of excellent oral health.

We have set up some guidelines to help you help us in ensuring that your child has positive dental visits.

You may choose whether or not you accompany your child to his/her appointment. Although we sense that some children do better without parents present, we are open to having you with your child. If you do choose to be present, we suggest the following guidelines to improve chances of a positive outcome:

1.) Be supportive of the practice's terminology.
2.) Do not share your 'bad' experiences with the child. Do not tell the child, "when I was little, the dentist did this or that to me"
3.) Please be a silent observer-support your child with touches, not words
    a.) This allows us to maintain communication with your child
    b.) Children will normally listen to their parents instead of us and may not hear our guidance
    c.) You may give incorrect or misleading information
4.) If asked to leave, be ready to immediately walk away
    a.) Many children will try to control the situation
    b.) "Acting out" is normal, but unacceptable if your child is getting a filling
    c.) This is intended to "short circuit" the control attempt by the child
    d.) We will continue to support your child at all times

Practice terminology:
In order to improve the chances of your child having a positive experience in our office, we are selective in our use of words. We try to avoid words that scare the child due to previous experiences. Please support us by NOT USING negative words that are often used for dental care. These include:

DON'T USE	**OUR EQUIVALENT**
Needle or shot	Wiggle numbing jelly
Drill	Mr. Bumpy, Mr. Whistle
Drill on tooth	Clean the tooth
Pull or Yank	Hug
Decay, cavity	Tooth bug
Examination	Count teeth
Explorer, 'stick thing', 'hook thing', poker	Tooth counter
Nitrous oxide, gas	Astronaut air, magic air
Cleaning	Tooth tickling

This will also help you understand your child's description of his or her experience. Our intention is not to fool your child, it is to create an experience that is positive. We appreciate your cooperation in helping us build a good attitude for your child! These are very important ways that you can actively help in the success of your child's visit. We are confident that all will go well and hope these guidelines will help prepare you with confidence for the upcoming appointment.

Signed:_____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You may refuse to sign this acknowledgment

I have received a copy of this office's Notice of Privacy Practices.

_____
Patient/s Name

_____
Guardian ~ Print Name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (please specify) _____

_____

Credit Card Pre-Authorization for Dental Treatment Form

Please complete & return with SIGNATURE

I authorize Melissa Padgett Dental to keep my signature on file and charge my Visa, Mastercard, American Express or Discover as indicated below.

Check one:

Visa _

Mastercard _

American Express _

Discover _

Balance of charges not covered by insurance

and not to exceed $ _____.

I assign my insurance benefits to the provider listed above. I understand that this form is a valid unless I cancel the authorization with written notice to the healthcare provider.

Patient (s) Name: _____

Cardholder Name: _____

Cardholder Billing Address: _____

City: _____ State: _____ Zipcode: _____

Card Number: _____ Exp Date: _____ Security Code:_____

Cardholder Signature: _____Date: _____

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